# **Individual Health Care Plan**

Date IHCP was created:

Date of review:

Out of School

## **Child/Young Person’s Information**

### **Personal Details**

|  |  |
| --- | --- |
| Individual’s name: |  |
| Date of Birth: |  |
| Address |  |
| Postcode |  |
| School |  |

|  |  |
| --- | --- |
| Medical condition(s): |  |
| Allergies: |  |

### **Parent/carer contact information**

|  |  |
| --- | --- |
| Parent/carer 1 |  |
| Name |  |
| Address |  |
| Relationship to child or young person: |  |
| Phone Number/s |  |
| Email Address |  |
| Parent/carer 2 |  |
| Name |  |
| Address |  |
| Relationship to child or young person: |  |
| Phone Number/s: |  |
| Email Address |  |

### **Professionals Involved with the child/young person**

|  |  |  |
| --- | --- | --- |
| Medical Professionals | Name | Contact details |
| Specialist Nurse(if applicable): |  |  |
| Consultant Paediatrician (if Applicable |  |  |
| GP |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| School Professionals |  |  |
| Class teacher |  |  |
| School nurse |  |  |
| SENCO |  |  |
| Other relevant non-teaching staff |  |  |
| Head Teacher |  |  |
| Any other relevant professional |  |  |

|  |
| --- |
| This child/young person has the following medical conditions… |
| 1. |
| 2. |
| 3. |
| 4. |
| …requiring the following medical treatments… |
| 1. |
| 2. |
| 3. |
| 4. |

### **Child/young person’s prescribed medication**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medical condition | Prescribed Medication | Dose | Method of administration | What time/s is the drug given | Who is responsible for administering |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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| --- | --- |
| Are there any side effects of the medication which impact the child’s day? |  |
| Does the child receive other treatment which can impact their day? |  |

### **Child/young person’s routine monitoring (if applicable)**

Some medical conditions will require monitoring to help manage the child/young person’s condition.

|  |  |
| --- | --- |
| What monitoring is required? |  |
| When do you need to monitor? |  |
| Who does the monitoring? |  |
| Does it require any equipment? |  |
| How is this monitoring carried out? |  |
| Do they have a care plan which gives guidance for the monitoring? |  |

## **Child/young person’s medical condition emergency situations**

An emergency situation occurs whenever a child / young person needs urgent treatment to deal with their condition.

|  |  |
| --- | --- |
| What is considered as a known emergency situation? |  |
| What are the signs and symptoms to look out for? |  |
| Is there anything which could trigger the situation? |  |
| What action must be taken and by who? |  |
| Are there any follow up actions required?  |  |
| Is there an Emergency Care Plan? |  |
| Who is responsible for writing and updating the Emergency Care Plan? |  |
| How often should the Emergency Care Plan be reviewed/updated? |  |

## **Child/young person’s needs at meal times**

|  |  |
| --- | --- |
| Do they have any food allergies/intolerances? |  |
| Do they have a special diet? |  |
| Do they require any additional support to eat and drink, or to manage their nutritional needs? |  |
| Do they use any special equipment to support their independence? |  |
| Do they require medication with their meal? |  |
| Do they require any other reasonable adjustments to support them at mealtimes? |  |
| Do they require any other reasonable adjustments for eating and drinking? |  |

## **Child/young person’s toileting and self-care needs**

|  |  |
| --- | --- |
| Do they require additional support with toileting? |  |
| Do they require any specialist equipment? |  |
| Do they require an accessible toilet and/or additional privacy for their toileting needs? |  |
| Do they require any reasonable adjustments to support them with accessing the toilet? |  |
| Do they need support with meeting their personal hygiene needs? |  |
| Do they require support with dressing and undressing? |  |
| Do they have a preference for who supports them with their toileting, personal care and/or dressing needs? |  |
| Do they require any other reasonable adjustments? |  |

## **Child/young person’s physical activity needs**

|  |  |
| --- | --- |
| Are there any restrictions to physical activities due to their medical/[physical condition(s)? |  |
| Is there any extra care before physical activity can take place |  |
| Is there any extra care whilst physical activity is taking place |  |
| Is there any extra care after physical activity has taken place |  |
| Do they require any other reasonable adjustments? |  |

## **Child/young person’s needs during trips out**

|  |  |
| --- | --- |
| Are there any reasonable adjustments required for transporting them to the destination? |  |
| Is there any additional support to what is usually required whilst they are on the trip? |  |
| Will they require an accessible toilet on the trip and will this need to be of a particular type? E.g. larger than average size/changing place toilet |  |
| Do they have any access requirements e.g level access, a lift, ramps |  |
| What equipment/medication is needed on the trip?  |  |
| Who will be responsible for the equipment and medication on the trip? |  |
| Who needs to give permission for them to go on the trip? |  |
| Who will take overall responsibility for them on the trip?  |  |
| Do they require any other reasonable adjustments? |  |

## **Child/young person’s environmental needs**

|  |  |
| --- | --- |
| Can the environment impact their medical/physical condition?(if so provide details) |  |
| What adjustments to the environment/support are needed?  |  |
| Where can they go to rest if they are unwell? |  |
| Do they require any other reasonable adjustments? |  |

##  **Child/young person’s social and emotional needs**

|  |  |
| --- | --- |
| How much do they understand about their condition? |  |
| Do they require support to explain to their friends what their medical/physical needs are if they wish to share this? |  |
| What support do they require with their emotional needs? |  |
| Do they require regular breaks? |  |
| Do they require a quiet space to rest? |  |
| Do they require any other reasonable adjustments? |  |

## **Staff training**

|  |  |
| --- | --- |
| What additional training do the staff require? |  |
| Who will need to be trained? |  |
| Who will deliver the training? |  |
| Who will arrange and book the training? |  |
| How often does the training need updating? |  |

## **Any Additional Information Not Covered Above**

|  |
| --- |
|  |

## **Are there any risk assessments in relation to the child/young person’s medical/physical condition? Attach a copy to this document**

|  |
| --- |
| Names of documents |
| 1. |
| 2. |
| 3. |

## **Sign off**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name | Signature | Date |
| Parents/carer if child is under 16 years |  |  |  |
| Young person if over 16 years and has the mental capacity to sign |  |  |  |
| Lead healthcare professional |  |  |  |
| Wrap Around Care/Holiday Club Manager |  |  |  |